

PUBLIC HEALTH REPORT

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The San Francisco Bay Area Resource for Cancer Epidemiology

THE SELECTION OF CANCER as the focus of a major health program to be organized and financed by the Federal Government places particular emphasis on cancer epidemiology. Recently, the Biometry Branch of the National Cancer Institute selected the San Francisco Bay Area, comprising Alameda, Contra Costa, San Francisco, San Mateo and Marin counties, as a resource for cancer epidemiology. An administrative unit, the San Francisco Bay Area Resource for Cancer Epidemiology, is being established in the State Department of Public Health to provide the Biometry Branch of the National Cancer Institute with a mechanism to coordinate epidemiologic, biometric, training and related interests.

From the Bay Area's three million population there are more than 11,000 cancer cases each year. The total includes enough cases of most cancer sites for study purposes and contains sizable ethnic subpopulations having differing cancer risks, including whites, Chinese, Japanese, blacks, Spanish-Americans, Filipino-Americans, American Indians, Samoans and Guamanians. Schools of medicine and public health in the Bay Area have long been engaged in cancer research, epidemiologic study and training in epidemiol-

ogy, and the Resource for Cancer Epidemiology will provide field training in cancer epidemiology for students.

The Resource for Cancer Epidemiology will combine the cancer epidemiology activities and the California Tumor Registry. Its activities will include cancer incidence determinations based on the five Bay Area counties serving as its geographic base, survival determinations, epidemiology and training.

Since 1960, the California Tumor Registry has accumulated incidence data from the Alameda County Cancer Registry, one of its units, covering the county's one million population. The registry is expanding incidence determination activity to include the entire five-county area, starting with cases diagnosed in 1972. This will increase population coverage for epidemiologic studies and sample sizes for incidence and survival computations, allowing inter-social class comparisons, as well as providing continuous current data on temporal, spatial and demographic trends in cancer incidence. The registry will carry out these activities through reporting of cases from the 73 hospitals that diagnose and treat about 11,000 new cancer cases annually. The California Tumor Registry will continue to work with hospitals throughout the state in its end results and survival data activities. The registry is a major contributor to the End Results Program of the National Cancer Institute, providing 40 percent of the data used by the Institute in the studies of survival of cancer patients.

The California Tumor Registry also conducts the San Francisco Bay Area section of the Third National Cancer Survey, collecting morbidity data for the five counties over the triennium 1969-71. A ten percent sample of cancer patients in the survey is interviewed for disability, medical care data, and related costs.

The cancer incidence determination system of the Resource for Cancer Epidemiology will collect case reports among Bay Area residents. They will provide essential information for planning and developing cancer epidemiologic studies to be carried out in the Bay Area, including determination of incidence rates, distribution, and ethnic sub-population comparisons.

The epidemiology section of the Resource for Cancer Epidemiology will carry out ad hoc cancer studies. It will develop data on environmental exposures and cultural practices of groups in the Bay Area, and offer the opportunity for collection of collateral data from laboratory studies of viral, genetic and cytologic nature, searching for clues to the causes of cancer. Representative studies might identify, for example, any influence of contraceptive drugs on breast cancer inci-

dence; genetic, biologic, social or cultural differences in breast cancer incidence among the several Bay Area ethnic groups; infectious or chemical agents from certain males that may induce cervical cancer in susceptible women; anatomic, anthropologic, infectious or hormonal causes of nasopharyngeal cancers; and differences in cancer incidence among migrant (for example, Japanese) as compared with native populations.

A board of professional advisors composed of representatives from various institutions interested in cancer epidemiology will consider feasibility of study proposals. The epidemiology section will be accessible to all individuals and institutions in the area interested in carrying out cancer epidemiologic studies.

SYMPTOMS OF DARVON® INTOXICATION

Darvon® is a drug in which the presentation in massive overdosage is as likely to be seizures as coma. I recently saw a woman who walked into the emergency room at a hospital in the city and said she had taken 15 Darvon capsules. Her doctor gave her a little syrup of ipecac. Between the time he administered the ipecac and the time it worked, a space of about 15 minutes, the woman rapidly lapsed into coma, had two grand mal seizures and a cardiac arrest. I was contacted at that point and arrived in the intensive care unit about 5 minutes after the patient. At that time she was having repeated seizures, a very characteristic presentation. So coma, respiratory depression, convulsions, and cardiac arrhythmia are common findings in Darvon intoxication.

Since Darvon is a narcotic, its effect is very well counteracted by Nalline® (nalorphine). Give 1 to 2 mg of Nalline intravenously at once, and you'll find the patient will begin to breathe almost immediately—within a minute or a minute and a half; and the seizure disorder will calm down very rapidly.

In young children there is a very rapid development of cerebral edema. If you get a history of possible Darvon ingestion, you ought to give nalorphine and at the same time begin the use of measures to counteract cerebral edema. You can use Mannitol®, urea, hyperventilation, steroids, or whatever approach you generally use—at once. Then you ought to use routine anticonvulsant management until the seizures are controlled.

—DANIEL T. TEITELBAUM, M.D., Denver
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